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ABSTRACT

Researchers have documented links between a number of behavioral issues and homelessness, including the following: limited/no social networks; social isolation; proneness of victimization; history of emotional, physical, sexual, and substance abuse; lack of education; and anxiety resulting from inadequate physical space. The possible benefits of self-directed learning (SDL) readiness in relieving the depression and symptoms of psychological trauma associated with the stressors linked to homelessness have already been established as have the similarities between the recognized cognitive treatment for forms of depression and the techniques used to develop SDL learning readiness. Social exchange theory and attachment and loss theory also shed light on the role of SDL readiness in helping homeless individuals, many of whom are from fragmented or abusive backgrounds. Implicit in the question of what SDL readiness can do to alleviate homelessness and its attendant psychosocial problems is the question of what SDL readiness can do to improve and lessen the frequency of circumstances preceding and contributing to homelessness. The documented benefits of self-help and goal setting in alleviating homelessness confirm that appropriate modules in SDL have much to offer homeless individuals and individuals living marginal lifestyles. (Contains 73 references.) (MN)

Readings

in

Homelessness

Peter F. Matuszowicz

1995

Homelessness is an enormous problem in the U.S. However, the phenomenon did not occur overnight without explanation. Neither do the majority of homeless people choose to be so. Homelessness may be more appropriately regarded as an extreme symptom with which numerous issues are associated. This paper is a review of the behavioral issues associated with homelessness and what part the concept of Self-Directed Leaming Readiness may play in addressing these issues.

Homelessness - The Issues.

Hutchinson, Stretch, Smith and Kretiger (1992) in studying The Haven Project found that most families admitted to the project had non-supportive social networks or no network at all from which they could obtain resources. It fell to social workers to intervene on behalf of these homeless families and facilitate linkages between them and their family members or professional service agencies so that appropriate support mechanisms could be established. Shinn, Knickmati and Weitzman (1991), Sumerlin and Norman (1992), Dail (1990) and Bassuk (1990) all report the same type of pattern.

Solarz and Bogat (1990) found that the homeless have extremely limited social networks in addition to which individuals would often manufacture imaginary networks simply to gain release from a program. They also found that many relationships reported in their study had a negative aspect to them. Half of the respondents in this study indicated knowing individuals, often relatives, who made their life difficult. Weinreb and Bassuck (1990) add to this concept by pointing out that many families prior to being homeless live in poor neighborhoods marked by physical and social deterioration with nowhere to turn in times of crisis. Burn (1992) is clear regarding the "Learned Helplessness" that individuals develop from exposure to such environments as well as from shelter life as described below.

Stark (1992a) reports that, as part of being a survivor, Henry does not admit to the fact that he has any problems, including medical ones. Denying his problems gives Henry the illusion he has control over a life that is in many ways governed by others. Stark (1992a), Huttman and Redmond (1991), Rivlin and Imbimbo (1989), Rivlin (1990b), all describe shelters as dictating when people eat, sleep and shower. Stark also identifies doctors who publicly argue over whether or not a person should be moved to another hospital without any regard for his / her own desires. Farge (1989) raises the same issue in that the cost of good care at a shelter is to distance oneself from any feelings or behaviors that might be in opposition to the aims of the hostel. An individual must "disavow more assertive strivings for greater self-determination." Grunberg and Eagle (1990) outline the same theme explaining in addition that no-one strives to improve themselves for fear they may be seen as a failure.

Ovrebo (1992) echoes the same sentiments as Stark (1992a), adding that independence from any assistance increases the status of shelter residents. Ovrebo also explains how residents are prone to romantic fantasies, fulfilling a need to have someone to care about without suffering any negative consequences in doing so. In other cases individuals isolate themselves in their hotel room, becoming

disoriented and losing the sense of self that one acquires from interaction in the social world. Homeless people also develop a sense of social valuelessness by internalizing the belief of the dominant culture that they and their peers are worth nothing.

Whitman, Accardo and Sprankel (1992) emphasize another element of the valueless issue inherent in stereotyping and labeling of homeless families by school authorities. Parents are viewed as incompetent rather than people in situational distress. Hence underlying, treatable difficulties are attributed to "Homelessness" and go unattended. Sadly, such labeling only goes to create an isolation problem, if one doesn't exist already, or fuel an existing one.

Indeed, Stark (1992b) ur-cs the reader to note that for political reasons, i.e. society's wishing to brush homelessness and associated issues under the carpet, many homeless programs have been long on treatment and short on reintegration, with many community mental health centers perpetuating negative stereotypes so as to leverage fundin- for pro-rams

Koegel (1992) highlights an ironic aspect of the isolation issue. A new 200-bed facility for chronically mentally ill homeless men remained significantly einpty because homeless people identified with strangers passing on the street, expecting that such people would provide help if needed, fearing the isolation that Ovrebo describes of a hotel room; One might even die without notice. In addition, Weinreb and Bassuck (1990) emphasize the high health and psycho social risks homeless families are exposed to because they frequently only use health care facilities episodically or during times of crisis.

Koegel's research also revealed that the shelter's admission procedures "allowed only the best-functioning clients with the highest tolerance for traditional services to survive the obstacle course one had to navigate in order to receive services". This situation is exactly parallel to that described by Hutchison "et al." of whole families being unable to meet the demands of a system, therefore requiring representation. One can also readily imagine individuals with a sense of pride refusing to be totally 'helpless' in order to qualify for services.

Despite such fears of isolation, Welte and Bames (1992) found that in the state of New York, compared to the general household population, a much larger percentage of the homeless and marginally housed are unmarried or separated and live alone. Quite reasonable by Coston (1990) and Farge, who found that many New York vagrant ladies were living on the streets to escape disastrous relationships or personal problems that they felt unable to cope with or found embarrassing. Initially these women were glad of the isolation and the time to think. Indeed, Coston comments that she saw three women from her sample return to normal lifestyles. Kurtz, Jarvis and Kurtz (1991) broaden the scenario with their investigation of homeless youth. Apart from abuse, from which youths run away, they document youths being thrown out by their parents / guardians, and youths who have been removed from one unsuitable environment by the state only to be placed in another unsuitable situation that they run away from. Mangine, Royse, Wiehe and Nietzel (1990) confirm this, estimating a representation of foster

care children among the homeless population four times greater than among the general population.

Homeless people are more prone than average to victimization as a result of their bizarre behavior and appearance. Street bullies regard them as easy prey (Fischer, 1992), especially as the dominant culture affords homeless people no credibility and consequently minimal protection, if any. Ironically, as Grunberg and Eagle point out, the very weak develop exagerated behavior patterns for what they perceive to be deterrence purposes only to be persecuted for the same.

Additionally, there is no doubt as to the high levels of emotional, physical and sexual abuse that men as children, women, women as children, mothers and their children experience prior to being homeless, Hunman and Redmond, Mills and Otta (1989), Shinn "et al.", Tyler, Tyler, Echeverry and Zea (1991), Dail, Browne (1993), Zozus and Zax (1991), Miner (1990), Buckner, Bassuk and Zima (1993). Another reason for social isolation and depression to develop as adults and children come to feel that they can trust no-one. Sadly, as Kruks (1991) writes, the same abusive situations recur once people are on the streets, embracing any glimmer of caring in a stranger that often turns out to be just another betrayal once the needs of the stranger have been met. D'Ercole and Struening (1990) deliver the same message with the addition of a significant relationship between depression and victimization; Alcohol and drug abuse being as likely as depression to be the result of victimization. D'Ercole and Struening also point to the debilitating effect that shelters may have on homeless people in triggering "flashback" to times when individuals were experiencing abuse and a concomitant lack of control over their lives; A reference to the control issues outlined by Stark (1992a), Huttman and Redmond, and Farge.

Jaheil (1992) found that, compared to domiciled groups, homeless people are significantly lacking in education. From 35 to 59 percent of homeless people had less than 12 years of schooling. Not good news considering since 1973 there has been a drop in the earning power of all but young college educated men (Burt, 1992). The Comprehensive Adult Student Assessment System [CASAS] (1989) found 68.8% of the homeless population 'In California not to have completed 12 years of schooling. Susser, Elmer, Struetiliig and Conover (1989) found 45% of their sample didn't graduate high school; Mills and Ota the same. Concurring with these studies Welte and Bames (1992) also found that half of the homeless and lowest income respondents in their study had less than a high school education. Burt and Cohen (1989) paint an even bleaker picture in that..."with the exception of single homeless women...(all homeless people) have even less (education) than the average American adult below the poverty line".

Welte and Barnes looked at drinking patterns in New York State. The study confirmed that alcohol abuse among the homeless and marginally housed is much more common than among the general household population of New York State. Although heavy drinking was not generally found to be associated with poverty, and homelessness not a significant cause of alcohol abuse, they concluded, as did Drake "et al." (1991), that alcohol abuse leads to homelessness. Weinreb and Bassuck (1900) believe substance abuse to be the most common

problem among the homeless. Being the result of self medication in an effort to relieve associated anxiety and distress, Weinreb and Bassuck, Farge, and Dail all indicate that substance abuse may exist prior to entering a shelter in the form of addiction while in other cases it only begins after entering a shelter. Calsyn and Morse (1991) found stress prior to homelessness a significant predictor of alcoholism, substance abuse being an accepted form of self medication that also facilitated socialization. Susser "et al" in their writing point similarly to distress occurring prior to homelessness as much as being exacerbated by homelessness.

As alcoholism is seen to precede homelessness, so Jahiel (1992) perceives the process of falling out of the job niarket a long one that also precedes homelessness. Furthermore, Welte and Barnes found the unemployment rate to be far higher among the homeless and marginally housed than among the general household population. Balkin (1992) also adds another dimension in definiiig typical low wage jobs of the homeless as exacerbating the situation because they are socially isolating, affording no opportunity for advancement.

Rosenman and Stein (1990) indicate families comprise the fastest growing sector of the homeless population, with anyny families never even requesting help for fear of dissolution by the very agencies that are supposed to be helping them; Dissolution being the price of shelter, the control issue already mentioned is again driving marginal or homeless people into isolation, avoiding assistance until crisis necessitates.

The transient nature of homelessness inevitably takes its toll on children too. Whatever the facility, cramped quarters force once private relationships into the public domain. The atmosphere in shelters or other cramped accommodation is often quite volatile. Bassuk and Gallagher (1990) explain that, for mothers in shelters, the result is a discharge of tension through argument, many times about children's behavior. Such argument often serves to promote a negative self image among the children.

A mother's understandable anxiety and depression regarding her functioning as a parent and her homeless situation leave little energy for consistent parenting. Overwhelmed by external stress or internal conflicts people often return to an earlier developmental level in the hope of meeting their needs. The outcome is that children become unruly and provocative in an effort to get more attention from depressed and anxious adults who are preoccupied with survival issues. The converse outcome regarding children is withdrawal and shyness as they feel unsafe, unable to trust anyone or express their feelings and needs openly. A further development of the parents inability to cope is that of role reversal, Hutmann and Redmond; Children making decisions for their parents and children being surrogate parents to younger siblings. The ambiguity of this situation only serves to further destabilize the children. Hausman and Hammen (I 993) and Bassuk (1993), Molnar, Rath and Klein (1990), all leave no room for doubt regarding the homeless parent's impaired ability to be a good parent as a result of the stresses of homelessness.

Rivlin (1990a, 1990b) without denying the significance of nurturing adults also explains the importance of two space related attributes for a growing child.

Firstly, "...the degree to which the physical proximity of others is comfortable .....the degree to which the stimulation of the surrounding can be filtered out or becomes aversive". Secondly, "...the ability to control inputs from the outside world: the ability to withdraw ... physically, by oneself or with others..... In developing proprietary interests over physical places and exercising these two space related attributes, children establish a sense of security. Confined accommodation denies children, and aduits, this sense of security, control and mastery over the demands of the outside world, the inability to personalize a space seriously softening their identity.

The issues above, as described by Goodman, Saxe and Harvey (1991), Miner, and Browne, whether associated with a gradual decline or a sudden crisis, including homelessness, are stressors of sufficient severity as to produce the symptoms of psychological trauma. That Self-Directed Leaming Readiness may be of assistance in relieving the symptoms of trauma has already been established (Matuszowicz, 1994).

Rosenman and Stein, Dail as well as Huttmann and Redmond concur regarding the range and scale of emotional problems exhibited by children (and adults), from aggressive to withdrawn behavior combined with depression, anxiety and stress. All this compounded by the inability to maintain friendships and exercise the requisite social skills of friendship as a result of living in constant transition; Another cause for homeless or transitory individuals to feel they have no control, this time over their social environment.

The Issues - A common Denominator.

The one outcome common to all experiences, behaviors and thinking patterns of the homeless or marginally housed, including the associated sense of helplessness and dependency, is depression, Hausman and Hammen, Gory, Ritchey and Mullis (1990), Browne, Siegel and Griffin (1984), Miner, and Rush (1983).

Rush divides depression into various categories. One might experience *'Normal'* depression after returning from a holiday or a visit with distant relatives. Normal depression is routinely self limited. *'Situational'* depression, perhaps in reaction to a bereavement, is as common as normal depression and may last up to a few months. Loss of one's job and income, forcing a move into shared accommodation would be a reasonable cause of situational depression. Indeed, just the threat of losing one's job is a reasonable stressor that might trigger situational depression.'The concomitant loss of such an important environmental / physical or emotional attachment results in a period of anxiety, fear, anger and protest followed by depression and despaii-.

*'Secondary'*depression results from another psychiatric or medical illness. Secondary depression might well be the result of medical negligence, alcoholism, drug abuse, schizophrenia, injury or stroke, all issues associated with marginal living or homelessness. Secondary depression is seen as a psychological reaction to a given illness. Secondary depression might also be the result of a chemical imbalance in the body caused by an illness or the legitimate prescription of medication used to treat a given condition. Although the more severe as well as

chronic cases of these depressions require professional help, Rush is clear that in many cases depressed people can help themselves.

However, caution must be exercised.'*Primary* 'depression occurs without a pre-existing or concomitant condition. In primary cases there is often a history of depression or suicide in the family. Primary depression is also generally associated with disrupted sleep patterns, appetite and sexual drive. Diurnal mood variations exist, generally worse during the morning. Primary depressed people think and behave very slowly, being unable to experience pleasure at all.

Furthermore, if a stressful / problematic situation does arise, the response is out of all proportion. Primary depression is also characterized by chronic episodes of severe depression that might alternate with severe mania. If an individual is depressed or manic they are considered *'Unipolar'*. If an individual alternates between periods of depression and mania they are defined as *'Bipolar'*. Manic behavior is associated with feelings of elation, euphoria or expansiveness. Manic individuals become inexplicably more active than usual. They talk a lot more than usual and experience difficulty communicating because they can't keep up with their thoughts. They are easily distracted, need less sleep and have an inflated self-esteem that may lead to their becoming delusional. Delusions do not allow the manic person to recognize the high potential for painful consequences their behavior entails. In extreme cases a manic individual hears voices and sees things.

It is imperative that primary depression be differentiated from other categories of depression. Treatment and stabilization of primary depression is not a job for amateurs! The recurrence and outcome of primary depression can be mitigated by the same cognitive treatment that milder depressions respond to. However, primary depression should be stabilized first and then treated educationally in conjunction with supervised psychiatric care.

The Common Denominator - A Recognized Treatment.

What is the accepted cognitive treatment of depression? In answering this question one needs be aware of a relationship between the occurrence of stressful life events and depression as elicited by Rush. Regarding the 'Normal' population an increase in life events is clearly associated with an increase in depressive symptomology. Similarly a decrease in the number of life events is associated with a decrease in depressive symptomology. Gory "et al." confirm the extrapolation with their findings. Whereas less than twenty percent of the normal population usually shows signs of 'possible depression', nearly 75% of their homeless sample indicated the same, with 59% indicating symptoms of 'probable depression'. To answer the question, the accepted cognitive treatment of depression lies in reducing the net number of stressful events that occur within an individual's life. Techniques used to reduce the occurrence of stressful events are detailed by Beck, Rush, Shaw and Emery (1979) as well as by Rush. Graded task assignments are used to increase self esteem, relieving apathy, self criticism and helplessness. The depressed person chooses a goal. This in itself creates the ownership of work associated with Self-Directed Learning (SDL). Whether one wants to complete a shopping trip or a small research project, the technique is the same. Itemize every step in the process to begin with. Test negative assumptions by catching a bus to

the shops and get home again without getting lost one day. Organize a ride from the shelter to a library and get back to the shelter on time one day. Next day catch a bus to the shops and enter the store to find out how the store is laid out and see if the store carries everything on the shopping list. Or, go back to the library again and go inside, this time to ascertain the presence of appropriate materials, including their referential location. Make a third trip to the shops, this time to establish prices and organize a budget upon another successful return home. Make a third trip to the library, go in and open the appropriate books to establish their informational worth. Make a fourth trip to the shops and buy. Make a fourth trip to the library and take notes or copy the appropriate pages. The pattern is clear.

With regard to goal setting as a part of Solution Therapy, DeShazer (1988) is emphatic:

> No matter how poorly described the future is, its salience is primary. Without the expectation that things can get better, therapy makes no sense. In fact, the expectation that things can get better is the central presupposition behind all therapy. (p. 191)

Future orientation and goal setting for DeShazer is achieved by asking people to describe circumstances without a given complaint. Conversation is constantly brought back to when a given complaint is not present. The next step is for the client to describe what steps may be taken toward achieving life without the given complaint. In common with SDL and a student's self set goals, DeShazer feels that this type of approach "can be seen as built on the assumption that the client constructs his or her own solution based on his or her own resources and successes " (p. 50). Furthermore, and again in common with SDL, DeShazer believes it more useful not just to set up goals but establish ways of measuring them. In performing this function both DeShazer and SDL modules ask the same question of a program participant, "How will you know when you have achieved your goal?" It also makes it a lot easier to work with people, creating more positive relationships, when focusing on what they are doing right.

Berg and Hopwood (1991) detail success using the same approach at their Brief Family Therapy Center. They were able to elicit what alcoholics and drug abusers do to abstain and thereby focus on creating longer and more frequent periods of abstinence and sobriety. By the same token, O'Hanlon (1987) in examining the work of Erickson attributes Erickson's success in psychotherapy to finding "out what they were interested in and what they were motivated to do and then link the therapy to that motivation" (,p. 25), again in keeping with SDL principles.

Psychotherapy in its most common form refers to the concept of individuals meeting as a group on a regular basis. Members are able to offer each other support by focusing on success and sharing their expertise in terms of solutions / means of achieving specific successes. Psychotherapy enables participants to focus on interpersonal behavior. Psychotherapy is also a means of anticipating obstacles and developing contingency plans, providing an opportunity to discuss such plans and learn of different perspectives. The social support that psychotherapy offers also provides the opportunity to be self critical, consider

alternatives and correct mistakes without falling to the typically depressed tendency of inferring personal inadequacy as a result of making a mistake. All these practices are central to SDL, where a group of individuals come to know and accept one and other as resources for learning, identifying the resources they can offer as well as need. Examining good and bad learnng experiences in relation to learnng styles improves self awareness and serves to remove personal responsibility for failure in a situation where outsiders inappropriately dictate learning methods. Offering and receiving feedback in a constructive manner requires a strong focus on interpersonal behavior.

Role playing to better elicit information from individuals, assisting individuals to identify their strengths and learnng styles are SDL practices that have already been identified as core psychotherapeutic depression beating interpersonal practices. Encouraging individuals to understand the feelings of both parties associated with the solicitation of assistance in learning and identifying methods of overcoming hesitation in askng for help are also awareness activities that closely parallel the accepted cognitive treatment of depression, focusing again on interpersonal skills and dealing with preconceived notions of personal inadequacy. That a group of individuals is encouraged to focus on the characteristics of a self directed learner, identify those skills that have helped them in their efforts and then consider how best to promote more of the same skills and habits is classic Brief Therapy Solution focus.

That a client should come to use the techniques practiced by a therapist represents classic psychotherapy. SDL is nothing short of the same in that, for example, students are shown how to question and use the decision making process as exhibited by the facilitator, going on to practice the same for themselves. The technique of examining the logical processes that are used to derive specific conclusions, a non-behavioral technique, is also common to both SDL and psychotherapy. Again participants in either program are introduced to a technique they then practice for themselves.

Another strength of psychotherapy alluded to by Rush "et al." is that "a strong social support system may provide such powerful evidence of acceptance, respect, and affection that it neutralizes the patient's tendency to downgrade himself" (p. 17) and as such be a strong buffer against depression. A strong social support network is always a real possibility, indeed a focal point, of a good SDL group.

Another important aspect of a SDL learning group relates to the development of trust between individuals as outlined in an analysis of The Social Exchange Theory [SET] (Gillmore, 1987). As already mentioned, for a variety of reasons, many homeless individuals have learned not to trust others and are at a disadvantage because of the resulting social isolation. Gillmore's analysis of SET shows us that individuals who are involved in limited quid-pro-quo exchanges are subject to fragile relationships that hold little or no trust. This is clearly a key characteristic of the majority of relationships endured by those who are either living in transition or homeless, already outlined above in discussion of The Issues. On the other hand, relationships as characterized in a SDL group are quite the reverse. In a SDL group, exchanges often take place between group members that

are not at all on a quid-pro-quo basis. One person may help a second individual who in turn helps a third person as opposed to the first person. SET characterizes such a situation as requiring a credit mentality under which circumstances participants are taking risks with other members of the group. Risk taking in turn generates a strong sense of solidarity between group members, generating the kind of trust marginal, homeless or abused people need to begin turning their lives around. Gillmore's work with SET substantiates this development of increased trust.

Attachment and Loss Theory expounded by Bowlby (1973) also sheds light on the role of SDL in helping the homeless, many of whom are the product of fragmented or abusive backgrounds. Children may be separated from their parent figure or live under threat of separation as is often the case in marginal or homeless situations. The insecurity that results from such a background is characterized by children and adults who form anxious attachments, even in the face of danger, rather than be left alone. Fear is typically aroused by strange and noisy environments or individuals as associated with marginal or homeless situations. The worst situation is realized when an individual, not uncommonly, acts in an angry fashion to coerce an attachment figure into remaining close, such anger only being checked by the threat of desertion by the attachment figure should the situation get out of hand. When an individual is angered to the point of threatening a coerced relationship is when one sees the anger inexplicably vented on outsiders, be that in frustration or with the aim of harming another. Although not a social panacea, there is no reason to believe that the relationships developed within a SDL group, as associated with SET, cannot be of service in relieving the sense of insecurity commonly associated with the fear of separation or loss of attachment figures.

That the outcomes of a SDL module and its commonalties with psychotherapy may be of assistance to the homeless is without question. Gory "et al." report that good health associated with better education are critical factors in determining the inner strength / mastery required to cope with homelessness. Improved education is probably the foremost outcome of SDL. Better psychological health would be a reasonable outcome of SDL, while physical health may be expected to improve as a result of psychological health and better planning associated with SDL. Additionally, it is not unreasonable to expect that a diminishing of the social barriers that interfere with the homeless seeking health care would result in better health..

Buckner "et al." have no doubt that homeless women will suffer economically for longer the poorer their ties to relatives and friends. Beyond this, that social relations and interpersonal skills are critical to the homeless situation needs no further emphasis. Indeed, the abilities to reason through situations that a SDL module develops should help homeless individuals avoid, perhaps for the first time, what are often recurring situations of detriment. Apart from avoiding detrimental situations, SDL does improve the ability of an individual to develop appropriate relationships. Kurtz "et al." call for the opportunity to fail and try again in a non traditional classroom setting with tutors and mentors, a concept

central to SDL. Tyler "et al." call for the input of young institutionalized individuals in developing, implementing and evaluating programs on the grounds that this would be self empowering, providing a sense of worth and belonging as opposed to creating dependent individuals with little sense of self worth. All prime functions for the structure of a SDL module.

Clearly, pooling resources and functioning as a team helped the squatter community studied by Rivlin and Imbimbo. It is also notable that the squatters, functioning as a group, failed to see themselves as personal failures because they were homeless, recognizing that political and economic factors had contributed to their situation. Often helping each other and sharing ideas and resources, there is no mention of the friction and withdrawal common to traditional shelters. What Riviin and Imbimbo describe are the functions of a SDL group in progress.

Mills and Otta, in looking at homeless women with minor children, call for child care that emphasizes skill development to end carry over of the social and psychological problems associated with homelessness into adulthood. This in itself is an unsung call for homeless mothers (and fathers) to develop the skills that accompany SDL. It would be somewhat contradictory not to work with both parents and children, especially since the conflicts that drive young people out of their homes unquestionably involve the parents as well as the children's inability to cope (Harris, Henley and Dominato, 1991).

Weinreb and Bassuck offer similar recommendations to deal with homeless families substance abuse problems. They call for residential treatment facilities that maintain the integrity of the family. Such integrity in part at least depends on the interpersonal skills and coping skills engendered by SDL. Even more justification is offered by Welte and Barnes who believe that abstinence is passed on from one generation to the next as is heavy drinking. SDL might well alleviate the need to self medicate hence reducing the likelihood of such habits being passed on. Koroloff and Anderson (1989) also report success for alcohol free residential centers where the "Social Model" replaces meetings. In other words new residents learn from working with peers who have been in recovery for longer periods of time, another example of the principles of SDL at work.

D'Ercole and Struening call for drop-in centers that mitigate the sense of fear from abuse and loss of control common to traditional shelter living. Although drop-in programs, as with SDL, are seen to provide more autonomy for the homeless or abused individual, the need by implication for a grasp of the life skills associated with SDL is even more immediate. Phrased more politically, Rosenman and Stein ask for programs that accelerate self sufficiency instead of throwing services at a problem while simply being careful not to encourage dependency. Commensurate with this view, Barker (1990) recommends instruction in social skills and discussion groups that might deal with how to get a job or how to relate to people from other backgrounds, be that socioeconomic or racial. The participants of a study conducted by Goering, Paduchack and Durbin (1990) spoke directly to their need to "avoid crises and emotional upsets, manage substance or legal problems, find something to do with their time and make friends"... as well as..."maintain a job, budget money, and use community services" (p. 792). All examples are

appropriately addressed with the skills and practises a SDL group aims to develop. All examples of Self-Directed Leaniing activities are taken from Rutland and Gugiielmino (1987).

Grigsby, Baumann, Gregorich and Gray (1990) indicate from the homeless themselves how important the typical activities of a SDL group are.

> "Information supplied by homeless individuals participating in a demonstration of case-managed job training for the homeless led to the conclusion that opportunities to discuss their problems with others and to receive advice and encouragement were as important to their progress as the training and employment assistance they received (The Resource Group 1989) (p. 153).

Even in dealing with the chronically mentally ill the best rehabilitation results will come from creating "an individualized plan..... based on the selfperceived needs of the client and will involve the client in the process of prioritizing his or her needs (Quam and Abramson, 1991, p. 25). Moxley and Freddolino (1991) concur with Qtiam and Abramson. Herman, Galanter and Lifshutz (1991) also confirm the preference of homeless substance abusers with psychiatric problems to utilize self-help programs.

The example of a successful street center as described by Pollio (1990) encompasses many of the principles of SDL in moving away from being crisis oriented. Clients augment the resources of the social worker, providing solutions to problems based upon common experiences that are quite removed from the experience of the social worker. In many cases clients have become essential to the functioning of the center, all at the center obviously teaching and leaming from each other.

Goering, Durbin, Trainor and Padtichak (1990) call for high levels of consumer involvement in developing successful permanent housing projects for the homeless. They indicate that the most successful projects have been managed by the residents themselves who are able to recognize their own problems. The role of SDL and associated skills will further assist residents depicted as able to recognize their own problems but wanting to participate in the development of solutions to meet their problems as opposed to having inappropriate solutions dictated by outsiders.

The Office of Adult and Vocational Education [TOAVE] (1992) is also calling for curriculums that promote self help and goal setting, utilizing the life experience of learners, encompassing their needs and interests. Additionally TOAVE is promoting programs that allow for peer tutoring and the sharing of knowledge among participants. Furthermore TOAVE is asking for assessment that measures the degree to which a participant is using their newly acquired life skills. What better method than to document a participatit's degree of self-directed learning which, all things being equal, will increase with a concomitant increase in coping skills and corresponding decrease in depressive symptomology.

Given that homelessness represents the end of a linear decline, many of the psycho social issues associated with homelessness are also legitimately associated with situations that precede homelessness and contribute to the problem as much

as being exacerbated by it, Hertzberg (1992), Dail. Browne (1993) points out that a substantial number of women suffering from Post Traumatic Stress Disorder developed the syndrome before becoming homeless. North, Smith and Spitznagel (1993) indicate that "the onset of antisocial behaviors almost always preceded the first episode of homelessness" (p. 582). While Wagner and Cohen (1991) write, "Since poor people are systematically cut off from many social ties which generate empowerment, they lack access to people and social networks available to middle class people, to organizations, to information, and to skills" (p. 553). Shinn (1992) writes, "efforts to *prevent* homelessness include efforts to empower tenants' groups, block associations, and communities to maintain existing housing, get essential services from landlords and local governments, and maintain their communities" (p. 21).

Therefore, in asking what Self-Directed Leaming Readiness can do to alleviate homelessness and its attendant psycho social problems one is implicitly asking what Self-Directed Leaming Readiness can do to improve and lessen the frequency of circumstances that precede and contribute to homelessness. A question Scott (1993) implicitly raises in her conclusions regarding the nonpsychotic issues associated with homelessness and the mentally ill. The same question is implicit in the work of Kurtz "et al.". The point being that, in conclusion, an appropriate module in SDI., unquestionably has as much to offer the marginal poor as the homeless.

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